Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING IL6008544 06/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 WEST NORTH 12TH STREET SHELBYVILLE MANOR SHELBYVILLE, IL 62565 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 Initial Comments S 000 Annual Licensure and Certification survey S9999 S9999 Final Observations Licensure Violations 300.610a) 300.1210 b) 300.1210d)2)4)A)D) 300.3240a) Section 300.610 Resident Care Policies The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary Attachment A care and services to attain or maintain the highest practicable physical, mental, and psychological **Statement of Licensure Violations** well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 06/29/19

If continuation sheet 1 of 6

Illinois Department of Public Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 1L6008544 06/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 WEST NORTH 12TH STREET SHELBYVILLE MANOR SHELBYVILLE, IL 62565 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S9999 \$9999 Continued From page 1 care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour. seven-day-a-week basis: Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: Each resident shall have proper daily A) personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect An owner, licensee, administrator, a) employee or agent of a facility shall not abuse or neglect a resident. These Requirements were not met as evidenced Based on observation, interview and record review, the facility failed to ensure pressure relieving interventions were implemented to

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prevent pressure ulcers for three of eight

PRINTED: 07/23/2019 FORM APPROVED Illinois Department of Public Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6008544 06/06/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1111 WEST NORTH 12TH STREET SHELBYVILLE MANOR SHELBYVILLE, IL 62565 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) S9999 S9999 Continued From page 2 residents (R22, R71, R276) reviewed for pressure ulcers in the sample of 41. This failure caused R22 to develop three Stage 2 Pressure Ulcers to the left upper buttock. Findings include: The facility's Pressure Injury Prevention and Treatment Protocol policy dated July 2016 documents the objective and purpose is to ensure that measures are taken to prevent skin breakdown and to provide guidelines for treatment of any pressure injury that might develop. This policy documents an individualized plan of care will be developed for the resident and all high and moderate risk residents may have the following and if so they will be addressed on the care plan-Special mattress and wheelchair cushions, passive range of motion, protein and/or nutritional supplements, turning and positioning schedule, skin checks and elbow/heel protectors/bridging of heels. This policy documents staff will be trained on pressure injury prevention and safety measures to be taken including proper positioning procedures. If residents are incontinent, perineal care will be given and the resident will be dried. When a resident is admitted to the facility or develops a pressure ulcer in the facility, the following will occur: Assess the pressure ulcer for location, size, wound bed, drainage, description. Determine the injury's current stage of

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development. For those residents that cannot reposition themselves, staff are responsible for assisting those residents. Special devices will be used to relieve pressure. All treatments and charting of pressure injuries will be done by licensed staff. This policy documents predisposing factors may include

bedridden/decreased mobility, past hip fracture,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
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	critically ill, incontin Diabetes, Periphera and Chronic End S Disease. 1. R22's Face Shee R22's diagnoses in Vascular Disease, I Anemia, Pain and F R22's Care Plans of at risk for skin breamobility, incontinent These Care Plans documents are relieving of R22's Admission O 6/3/19 documents with two staff assis pressure sore risk documents R22 is sores. On 06/04/19 11:05 AM was sitting up in R2 R22's room. At each pressure relieving of R22's electric wheelift sling was under	ed, contractures, obese, ence, previous pressure injury, al Vascular Disease, Edema, tage Renal, Liver or Heart et dated 6/3/19 documents cluding Diabetes, Peripheral Edema, Protein Deficiency Parkinson's Disease. Idated 5/6/19 document R22 is akdown due to decreased ace, edema and Diabetes. document R22 has a Stage II ow the right buttock fold. R22's ent interventions including a cushion to R22's wheelchair. In the servation Report dated R22 requires a mechanical lift tance to transfer. R22's assessment dated 6/3/19 at a high risk for pressure AM, 06/04/19 01:42 PM, and 06/05/19 11:08 AM R22 22's electric wheelchair in the of these times: R22's cushion was in the seat of elchair and R22's mechanical R22 positioned between R22			
	and the pressure re	elieving cushion.			
	Nursing Assistant (R22. R22 was in R the mechanical lift	AM V15 and V16, Certified CNA's) provided cares for 22's electric wheelchair with sling under R22. V15 and V16 care to R22 and turned R22 to			

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Illinois Department of Public Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 06/06/2019 IL6008544 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1111 WEST NORTH 12TH STREET SHELBYVILLE MANOR SHELBYVILLE, IL 62565 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S9999 S9999 Continued From page 4 finish providing cares to R22. There were three pressure ulcers to R22's left upper buttock area that were not documented as current pressure ulcers in R22's medical record. On 6/5/19 at 11:34AM, V7, Wound Nurse, provided wound care to R22's Stage II Right Buttock. V7 confirmed there were three new Stage II Pressure Ulcers to the Left Upper Buttock, V7 stated, the three areas are "new" and all three are "pressure ulcers, stage II." R22's Progress Notes dated 6/5/19 at 12:02pm document R22 "noted to have Stage II Pressure" ulcers to the left buttock measuring as follows: 1-0.5cm (centimeters) by 0.3cm; 2-1cm by 0.9cm; 3-2cm by 0.3cm. 06/05/19 03:42 PM R22 observed sitting up in R22's electric wheelchair looking out the window in R22's room with a mechanical lift sling gathered up under R22 on top of R22's pressure relieving cushion. On 6/6/19 at 12:30pm, V2, Director of Nursing stated R22's mechanical lift sling should be removed after R22 has been transferred in to R22's electric wheelchair and should not be left under R22, so it does not interfere with the pressure relief the cushion is to be providing to prevent R22 from developing pressure ulcers. On 6/6/19 at 2:35pm R22 was up in R22's electric wheelchair in R22's room with a mechanical lift sling positioned between R22 and the pressure relieving cushion. The manufacturer's guidelines for the pressure relief cushion dated with the year of 2015 document "DO NOT" place anything between the

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Illinois Department of Public Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: ___ B. WING IL6008544 06/06/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1111 WEST NORTH 12TH STREET SHELBYVILLE MANOR SHELBYVILLE, IL 62565 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) \$9999 S9999 Continued From page 5 user and the product as additional materials may reduce the effectiveness of the product and increase risk factors for skin breakdown and instability. (B)

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